PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

Michigan -- Person Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities

Issue: Increasing Access and Choice Through Person-Centered Planning

Summary

The State of Michigan combined several funding sources in its contracts with local community mental health agencies, which serve people with developmental disabilities, mental illness, and addiction disorders. To ensure access and improve choice, the contracts require that local agencies offer a wide array of services and use a person-centered planning process to determine a person's service plan. This model has been successful in improving access to services and reducing costs.

Introduction

To offer more service options and improve service coordination among several programs, the State of Michigan developed a model to finance services for people with mental illness, addiction disorders, and developmental disabilities. The model combines several funding streams into one managed care contract, making it easier for a person and his or her Community Mental Health Services Program (CMHSP) to create one person-centered plan for services from several payment sources. Michigan contracts with 49 CMHSPs as health plans for these services. These plans are referred to as Prepaid Inpatient Hospital Plans (PIHPs). Rather than present participants a choice among prepaid health plans, Michigan's model focuses choice at the level of selecting services and providers.

Michigan contracts with its Community Mental Health Services Programs as health plans.

This report briefly describes Michigan's model, its implementation, the impact of the model to date, and recent changes to the model. The document is based on interviews with current and former state staff who implemented the model, a conference presentation by a state staff person, written reports from the state, and a case study by Medstat that examined this system.

Background

CMHSPs are Michigan's traditional, county-level community mental health providers, planning and implementing publicly funded services for people with mental illness, addiction disorders, and developmental disabilities. Michigan calls services for these populations "specialty services," a phrase this report also uses. Within its service area, each CMHSP is a single access point for people seeking publicly funded specialty services, including Medicaid and other state-funded services.

It is easier to create one person-centered plan for services from several payment sources.

CMHSPs were established in the 1970s and their duties have expanded since then. For example, in the 1980s CMHSPs were given the option to serve people discharged from a state hospital, using money the state would otherwise have spent for that person's hospitalization. In the early 1990s CMHSPs' responsibilities expanded to include authorization and monitoring of inpatient psychiatric hospital stays.

In the mid-1990s, Michigan passed legislation designed to increase individual choice and responsibility in specialty services. The law required person-centered planning – a process for planning services based on a person's strengths, choices, and preferences – for

publicly-funded specialty services. People were able to choose among available services and providers. However, new options, such as peer-delivered services and in-home mental health services, were not available in all parts of the state.

Intervention

Michigan began the implementation process for its new financing model in 1998 when the Health Care Financing Administration (HCFA) approved a 1915(b) waiver establishing Michigan's Medicaid Managed Specialty Services program covering Medicaid supports for persons with serious mental illness, serious emotional disturbances, developmental disabilities, and addictive disorders. To comply with Medicaid managed care regulations, providers in this plan were required to be designated under contract with the state as Prepaid Inpatient Hospital Plans or PIHPs. When the plan initially went into effect, the state designated each CMHSP to operate as a PIHP in its respective service area. As part of its waiver renewal application in 2000, Michigan submitted a revised procurement plan which restricted initial PIHP consideration to CMHSPs alone, while imposing a detailed set of qualification criteria that CMHSP applicants needed to meet. If a CMHSP could not meet the qualifications, the PIHP contract would be open for competitive solicitation. The contracts for these new PIHP plans were ultimately awarded to 18 CMHSPs.

To increase service options, the PIHP's managed care contracts include a minimum set of services that must be available, including newly developed services. The contracts also give PIHPs flexibility to offer additional services. The state expected that cost savings from implementing the managed care model would enable PIHPs to afford the development of new services.

All Medicaid participants in Michigan who receive specialty services receive them through this model. Each PIHP serves as the sole primary health plan for specialty services in its area. This model is separate from Medicaid financing for medical services. Michigan has required most Medicaid participants to join Medicaid managed care plans since 1997, but mainstream Medicaid managed care plans do not cover specialty services beyond a limited number of outpatient mental health visits.

Michigan pays PIHPs a set amount for each person each month (capitated payment), instead of paying the specialty service providers directly for each service. The capitated payment is based on the historical costs for specialty services. This requirement added financial management and other managed care functions to the PIHPs' duties to plan and implement specialty services in a region. Each PIHP's contract with the state contains guidelines for operating a health plan (e.g., claims processing, customer service). The contracts also include provisions to ensure people have prompt access to services.

Michigan uses a combination of Medicaid waivers authorized by sections 1915(b) and 1915(c) of the Social Security Act to secure Medicaid payment for the managed care model. The 1915(b) waivers allow Michigan to restrict participants to PIHPs and their contracted providers. The 1915(c) waiver, a home and community-based services waiver for people with developmental disabilities, was changed to include these services in the managed care benefit package.

The primary challenge was preparing CMHSPs to become managed care plans.

The State also uses a population-based formula to award PIHPs grants to finance specialty services for persons who are not eligible for Medicaid. Michigan funds these grants using federal block grants and State general revenue. The grants are not based on capitation and are not related to the Medicaid payments.

Implementation

The primary challenge to implementing the managed care model was preparing the CMHSPs to become PIHPs. CMHSPs had to develop several new organizational functions, including information systems, claims processing, financial management, and appeal and grievance procedures. The CMHSP association and state staff provided a great deal of training and technical assistance to CMHSPs.

CMHSPs also could subcontract with existing health plans to build this capacity.

Previous expansions of CMHSPs' duties eased the transition to a managed care model. CMHSPs authorized inpatient services and coordinated outpatient, in-home, and community services, so they had previous experience with the entire spectrum of specialty services. This made the transition to managed care easier than it would have been for an agency that had not had experience in both community and institutional services.

A precise dollar figure for state implementation costs is not available because these costs were not tracked separately. The state used existing staff to implement the managed care model, which required several employees working full-time for more than two years.

Impact

Michigan developed a set of performance indicators for CMHSPs before implementing the managed care model. Several access indicators suggest that access has improved since the model began. For example, among all target populations (people with mental illness, developmental disabilities, and addiction disorders) the wait between an assessment for non-emergency services and receipt of services decreased. Also, the proportion of people with serious mental illness using services increased. Other performance indicators suggest little or no change. For instance, the proportion of Medicaid participants using specialty services remained constant.

In state fiscal year 2002, Michigan spent $1.8 billion on specialty services, serving over 195,000 people. Total Medicaid capitation payments were $1.52 billion and grant awards totaled $318 million. These funds served over 161,000 people with mental illness and over 31,000 people with developmental disabilities. An independent evaluation concluded the transition to a managed care model reduced costs for each target population. Estimated savings for mental health services were $0.01 per eligible person per month (PEPM), while savings for addiction disorders services were $0.12 PEPM, and savings for developmental disabilities services were $10.16 PEPM.

Contact Information

For more information about Michigan's managed care for people with mental illness, addiction disorders, and developmental disabilities, please call Irene Kazieczko of Michigan's Department of Community Health at (517) 373-4783 or kazieczko@michigan.gov. A more detailed report examining Michigan's Managed Specialty Services System is available on the CMS Promising Practices website at http://www.cms.hhs.gov/promisingpractices/mimsss.pdf. More information about the model is available on the Internet at **http://www.michigan.gov/mdch.**

Some Discussion Questions:

When services for people with disabilities are provided through a different health plan than medical services, what coordination of care issues arise?

Would a similar model be effective for other target populations?

One of a series of reports by Medstat for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series is available online at CMS' web site, http://www.cms.hhs.gov/promisingpractices. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.